

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

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✓ 8

1. PLACE OF DEATH
 County Janey Registration District No. 859
 Township Bronson Primary Registration District No. 6128
 City Bronson (No. _____) St. _____ Ward _____

File No. _____
 Registered No. _____

2. FULL NAME Golda Blyer
 (a) Residence No. _____ St. _____ Ward _____
 (Usual place of abode)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX ♀ 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Child
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Child
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 3 - 1926
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 6 10
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Child
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Janey Co Mo

10. NAME OF FATHER Riley Blyer
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Stone Co Mo
 12. MAIDEN NAME OF MOTHER Alma Blyer
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Stone Co Mo

14. INFORMANT Riley Blyer
 (Address) Bronson

15. FILED 4/14 1927 PA Thornhill
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-13 1927
 17. I HEREBY CERTIFY, That I attended deceased from April 13, 1927, to April 13, 1927, that I last saw her alive on April 13, 1927, and that death occurred, on the date stated above, at 5:30 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
100
Obstetrical trouble & a cold
 (duration) 24 yrs. mos. da.
 CONTRIBUTORY Inanition
 (SECONDARY) (duration) life long da.
 18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH, X
 DID AN OPERATION PRECEDE DEATH? No DATE OF X
 WAS THERE AN AUTOPSY? No
 WHAT TEST CONFIRMED DIAGNOSIS? None
 (Signed) Officer Richardson, M. D.
 , 19 1927 (Address) Bronson Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Bronson Cemetery DATE OF BURIAL 4/14 1927

20. UNDERTAKER W. W. Whelchel ADDRESS Bronson

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1000 10/10/10

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Daney Registration District No. 8578 File No. 8
 Township Granston Primary Registration District No. 6128 Registered No. _____
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Golda Blyen
 (a) Residence, No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX D 4. COLOR OR RACE H 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) S

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) _____

| 7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, | |
|--------|-------|--------|------|---------------------|------|
| | | | | hrs. | min. |
| | | | | | |

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____
 (STATE OR COUNTRY) _____

10. NAME OF FATHER _____

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) _____

14. INFORMANT _____
 (Address) _____

15. FILED 4/14 22 P. Thorne
 19____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 13 1927

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, 19____ that I last saw him alive on _____, 19____, and that death occurred, on the date stated above.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Stomach trouble & acute unknown
 (duration) yrs. mos. ds. _____
 CONTRIBUTORY (SECONDARY) infection
 (duration) yrs. mos. ds. _____

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) _____, M. D.
 , 19____ (Address) _____

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____

20. UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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